



**KVC Kentucky Treatment Referral Form**  
Behavioral Health Services &  
Alcohol, Substance Abuse and Co-Occurring Disorders

**Client Information**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ County: \_\_\_\_\_

Legal Guardian Name (if different than client): \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Is guardian aware of the referral?  Yes  No

Gender:  Male  Female

Ethnicity:  African American  Asian  Caucasian  Hispanic  Other: \_\_\_\_\_

Primary Language: \_\_\_\_\_ School: \_\_\_\_\_

The Client's Age Is:

17 Years or Younger \_\_\_\_\_ 18 Years or Older \_\_\_\_\_

**Insurance Information**

Medicaid #: \_\_\_\_\_

MCO Insurance Provider: \_\_\_\_\_ MCO Insurance ID #: \_\_\_\_\_

Primary Insurance Provider: \_\_\_\_\_ Primary Insurance ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

Secondary Insurance Provider: \_\_\_\_\_ Secondary Insurance ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

**Reason for referral and presenting problems:**

**Does the client use tobacco, alcohol, or illegal drugs, including prescription medication for non-medical purposes?**

Yes     No

**Does the client have current suicidal or homicidal thoughts or behaviors?**

Yes     No

**Within the last 6 months, has the client received in-patient services in a psychiatric hospital, residential treatment facility, substance treatment facility, or crisis stabilization unit? Has the client had a mobile assessment in the past week?**

Yes     No

**If yes, what were the treatment recommendations?**

**Was a higher level of care recommended or discussed?**

**If a higher level of care was recommended and not referred, what were the symptoms/behaviors of concern at discharge/during the mobile assessment and barriers to the client accessing this level of care?**

**Has the client engaged in violence towards others, made threats of violence, or used weapons against others?**

Yes     No

**Has the client engaged in self harming behaviors in the past month?**

Yes     No

**Are there any concerns about adult violence in the home?**

Yes     No

**Are there any concerns about adult alcohol and/or illegal drug use, including prescription medication for non-medical purposes, in the home?**

Yes     No

**Are there any barriers or concerns about KVC providing behavioral health services in the home?**

Yes     No

**If Yes, what are the concerns about KVC providing services in the home?**

**Referral Source Information**

Referring Agency:

Referring Agency Contact:

Address:

City:                      State:                      ZIP:

Phone:                      Email:

How did you find out about us?